Medical Readiness Transformation Profiling Team PROFILE REQUEST LETTER OF INSTRUCTION (LOI)

This form is subject to Privacy Act of 1974. The proponent is USARC SURGEONS OFFICE.

Complete the following information. All fields are mandatory.

1.	NAME (Last, First, MI):	DOD ID:			
2.	Unit POC	POC Phone:		Unit Nan	ne and UIC:
	CDR Name and Rank:	CDR Phone N	lumber:		
3.	Profile Request Type: (must select one)	Permanent		Profile for Condition(s):	
	Profile Request Status (must select one)	: Continue	○ Expire	list all	
4.	Required Document (Checklist (check	all items subr	nitted with this	packet)
	Cummary of Co	ro by Civilian Prov	ider Form (oo	nagae 2 and 4)	
	O Summary of Ca	re by Civilian Prov O	,	pages 3 and 4)	
	Personal Provid	ler Letter on Office	Letterhead ar	nd signed by pro	vider
	(Prescription Pad is	S UNACCEPTABLE)			
	☐ Diagno		☐ Diagnosti	c Imaging Reports	
		Limitations	Labs		
	_	mitations (if any)	☐ Treatmen		
	☐ Time le	ngth of limitations	Prognosis	s for improvement	
	NOTE: Letters from Ch	niropractors will be	accepted for r	nusculoskeletal	conditions only
5.	CERTIFICATION: I certify that this Medical Fincomplete or inaccurate in				
	Signature:			Date:	

Email completed documentation to usarmy.usarc.usarc-hq.mbx.mrt-profiling-team@mail.mil

a. SUBJECT LINE: "Attn:

^{*} While not mandatory, use of Military e-mail with encryption is Strongly encouraged

Profile Onlinuation Packet

MEDICAL RECORD - CONSENT FORM

Authorization To Send Ar For use of this form see, MEDCo	OM Supplement 1 to	AR 40-66; the		-		
NAME (Last, First, Middle Initial)	2. DATE OF BIRTH		0) 3.	SOCIAL SECURITY NU	JMBER (Last	four only)
4. E-MAIL ADDRESS				TELEPHONE NUMBER	२	
	ION II - CONDITIONS F					
Health care providers cannot guarantee but will use reasonab	le means to maintain	security and c	onfiden	tially of electronic mail (E	E-mail) informa	ation sent
and received. You must acknowledge and consent to the fol	lowing conditions:					
1. E-mail is not appropriate for urgent or emergency situati	ons. Healthcare prov	iders will resp	ond with	in	<u> </u>	
Contact the clinic telephonically if you have not receive	ed a response after					
2. E-mail must be concise. You should schedule an appoi	ntment if the issue is	complex or se	ensitive	precluding discussion by	v E-mail.	
E-mail should not be used for communications regarding		· ·				
HIV/AIDS, spouse or child abuse, chemical dependen	•			,		
·	•	26				
4. Medical or dental treatment facility staff may receive an		55.				
5. E-mails related to health consultation will be copied, pa		TIONS E MAII				
	ECTION III - RISKS OF		Direction of	A. Alex Fall and a selection		
Transmitting information by E-mail has risks that you should			limited	to the following risks:		
E-mails can be intercepted, altered, forwarded. or used values.	without authorization	or detection.				
2. E-mails can be circulated, forwarded and stored in pape	r and electronic files.					
3. E-mail senders can easily type in the wrong E-mail add	ress.					
4. E-mail may be lost due to technical failure during comp	osition, transmission,	, and/or storag	e.			
	SECTION IV - PATIENT	GUIDELINES				
To communicate by E-mail, the patient shall:						
1. Place the category (topic) of the communication in the sadvice, etc.)	subject line of the E-r	mail (for examp	ole, app	ointment, prescription, m	nedical	
2. Include the patient's name, telephone number, family m	ember prefix, and the	e last 4 numbe	rs of the	e sponsor's social securi	tv number	
(for example: 30/0858) in the body of the E-mail.	,				.,	
	so by a boalth care	orovidor				
3. Acknowledge receipt of the E-mail when requested to do	•			anaant farm		
4. Inform the medical or dental treatment facility of change						
5. Notify the health care provider of any types of informatio	• •	patient to be in	appropri	ate for E-mail.		
6. Take precautions to preserve the confidentiality of E-ma						
	PATIENT ACKNOWLED					
I have read and fully understand the information in this author above. I futher understand that this E-mail relationship may be				•	by the guidelir	nes listed
I understand and accept the risks associated with the use of	unsecure E-mail con	nmunications.	I furthe	r understand that, as wit	h all means o	f electronic
communication, there may be instances beyond the control of						
exposed, such as during technical failures, acts of God, acts				ore innormation may be re		J
exposed, such as during technical failures, acts of God, acts	or war, and 30 form.					
I understand that I have he right to revoke this authorization, i	n writing, at any time					
By signing this form I acknowledge the privacy risks associated	ed with using E-mail	and authorize	health o	care providers to commu	ınicate with m	e or any
minor dependent/ward for purpose of medical advice, educati	on, and treatment.					
(Date) SIGNATURE of Patient or Pare			RE	LATIONSHIP (if other that	an patient)	
PATIENT IDENTIFICATION (For typed or written entries note: Name	-last, first, middle	atient's Name				Sex
initial; hospital or medical facility)		ear of Birth	Pelatio	nehin to Sponeor	Component/	Statue
] **	cai UI DII (II	ixeiali0i	nship to Sponsor	Component/s	Jiaius
		 epart/Service		Sponsor's Name		
		cpai i/Oci vice		oponsor s Name		
		ank/Grade		FMP-SSAN (Last four o	only)	
		unin Oraut		I IVII -OOMIN (LASTIOUI (orny)	
	Oi	rganization		l		

Profile Onlinuation Packet

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE		SYMPTOMS,	DIAGNOSIS,	TREATMENT,	TREATING OF	RGANIZA	ATION (Sign e	ach entry)		
NOTE TO MEDICAL PRO CONDITION(S) FOUND TI	DVIDER: YO	MARY OF CAR UR PATIENT IS A SO	E BY NON LDIER. THIS FO BILITY TO PERI	-MILITARY ORM WILL BECON	MEDICAL ME PART OF THE	PROVIEIR OFFI	VIDER CIAL MILITARY (LISTED BELOV	HEALTH R	RECORD.	
Is this a request for a new	v profile or a	request to continue	a permanent pi	rofile written prio	or to 01JUN17?	Check or	ne: New \square	Continue	e 🗆	
		E XAM (TO BE COM								
2. What medical conditions v	were evaluat	ed today? For acute i	njuries, please	describe mechan	nism of injury an	nd when it	t happened.			
D. Bloom the deliberation		I : I - b : - f			11-1					
3. Please attach lab and x-ra	ay results and	a provide brief summ	ary or pnysical,	radiological, and	ı ıab exam tındı	ngs:				
4. Does the patient have any	v allergies wi	ith severity that requi	res eni-pen (m	edications, food.	insects (bees, v	vasos, fire	e ants), grass, r	lants, etc.	? If YES	
Please List:	, unergies m	ar severity triat requi	res epi peri (iii	cuicadono, rood,	maccas (acca, v	таоро, пт	c ana,, grass, p	names, etc.,	,. 11 TES,	,
5. What medication(s) does t	the nationt t	ako (procerintion ove	or the counter	vitamine/mineral	e cupplomonte	\2 Dloaco	Lict			
5. What medication(s) does i	trie patient t	ake (prescription, ove	er une counter,	vitarriiris/minerai	s, supplements,): Please	LISL.			
II. DOES THE PATE	IENT HAV	E ANY OF THE FO	LLOWING (CONDITIONS	(TO BE COMP	LETED E	BY MEDICAL P	ROVIDER):	
6.	YES		YES			YES				YES
a. ADD/ADHD	ILS			c. Arthritis/Joir	at Dain		1 - 1 - 1-1			
a. ADD/ADHD		b. Anxiety		C. ALUTTUS/JOIL	nt Pain		d. Asthma/Sh	ortness of	Breath	
		b. Anxiety f. Depression		· ·		$+\Box$	d. Asthma/Sh	ortness of	Breath	
e. Concussion/TBI/Head Trauma		f. Depression		g. Diabetes/Hi	gh blood sugar		h. Dizziness		Breath	
e. Concussion/TBI/Head		f. Depression j. Headaches/Migra		· ·	gh blood sugar		h. Dizziness I. High chole	sterol	Breath	
e. Concussion/TBI/Head Trauma		f. Depression		g. Diabetes/Hi	gh blood sugar		h. Dizziness	sterol	Breath	
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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 11/2010) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

DOB

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	31Wii 10	MS, DIAGNOSIS, TREATMENT,	TREATING OF	RGANIZATION (Sign e	each entry)		
	events in the Army Physical Fitnes	ss Test (APFT)				YES	NO
16. Able to perform two							П
If unable to perfor 17. Able to perform two i		on(s) contribute to this limitation?					
		lition(s) contribute to this limitation?					
18. Able to perform timed	2-mile run?						
 If unable to perform 	m timed run, which medical cond	dition(s) contribute to this limitation?	?			ᅵ	Ш
	m the timed 2-mile run , can yo	our patient participate in a timed alte	rnate aerobic e	vent? (check all that app	ply)		
2.5 Mile Timed Walk IV. DIAGNOSIS		ry Bike (800 Yard Timed S BY MEDICAL PROVIDER. PL		CLECTRIAN.			
		BE COMPLETED AND SIGNED B			TDER		
****		t's Limitations in section IV is import			IDER		
19. Diagnosis:	·	·					
20. Treatment Plan (exar	nple: X Rays, Physical Therapy, M	/ledication):					
21. Follow Up:							
22. Ph		T	-£ 41 1::4-4:-	-/-\ :- f	D (11 00)		
22. Physical Limitations	are: Permanent or	Temporary: the expected duration	or the limitatio	n(s) is for	Days (Max 90)		
Can the patient take	record Army Physical Fitness Tes	st <u>now</u> (Refer to 16-18 above)? Ye	s □ No □ I	f No, when can they? (e	enter date)		
Medical Provider's Full Na	me (Print or Type):						
Medical Provider's Medica	l Degree (MD, DO, NP, PA):	Medical Prov					
Medical Provider's Specia	lty:	Medical Prov	rider's Full Sign	ature:			
Office Telephone Area Co	de & Number:	Eilidii Address	rea Code Numb	er:			
omeo reiepnone / a ea ee	ac a manberi		rea code manne				
		PRIVACY ACT STATEMENT	TV				
PRINCIPAL PURPOSE(S):	1, Secretary of the Army; AR 40-501 This form is used to assess a Soldier'	PRIVACY ACT STATEMENT Standards of Medical Fitness, AFI 48-123 Substituting specific states of the developm of	Medical Examina	tions and Standards. a temporary and permanent			
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STANDARD FORM 600 (REV. 11/2010)

Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

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